Assessment Date:_____

PRESENTING PROBLEM: (Identifying Data/Chief Complaint and History of Present Illness. Summarize client's request for services including client's most recent baseline and the subjective description of the problem. Include precipitating factors that led to deterioration, and describe events in sequence leading to present visit. Include objective impairing behaviors, including experiences and stigma, if any, and prejudice and client's requests/needs).

PAST PSYCHIATRIC HISTORY: (Previous mental health treatment; in chronological order; where, when, for how long. Include dates/providers related to any prior psychiatric treatment, history, traumatic and/or significant events, include immigration history, and impact if any. Describe most recent periods of stability and the characteristics of those periods).

FAMILY HISTORY:

Any family members with a history of any of the following? (Please, check all that apply):

	Depression	Schizophrenia	Bipolar	Substance Use	Suicide	Other	Effective Treatments
Parent							
Sibling							
Children							
Aunt/Uncle							
Grandparent							

CULTURE/FAMILY and RECOVERY POTENTIAL:

Birth place: ( )San Diego ( )USA ( )Other (fill in birth place and year moved to USA):

Language of choice for therapy: ☐English ☐Spanish ☐Vietnamese ☐Other(fill in Language)

Ethnicity: ☐ Latino/Hispanic ☐ African American ☐ Asian/Pacific Islander (fill in):

☐ White ☐ American Indian ☐ Other (fill in):

Culture specific symptomatology/explanations for behavior (May reference Appendix I of DSM-IV-TR)

Family/Community Support System- (Describe it, including alternative relationship support, if any for mental health and/or substance use. Who is supportive? Community groups, e.g. AA/NA).

Socio-Economic Factors: (Educational achievement, occupation, income source and level).

Religious/Spiritual Issues: (Is R/S important in your life? If yes, is it a source of strength in your recovery process? Describe how/who: persons, practices).

ASSETS/STRENGTHS: (What abilities or skills do you have that you would choose to develop during your recovery? What new ones might you choose to develop? Describe strengths that contributed to recent treatment successes, sobriety, etc).

MEDICAL HISTORY: (Indicate any significant medical history related to client's current mental health or substance use condition, including dates/providers related to prior treatment, as well as client's adjustment to co-occurring disabilities).

Current Medication(s)	Dose	Frequency	Taken as Prescribed?
			☐YES☐NO
			☐YES☐NO
			☐YES☐NO
			☐YES☐NO

ALLERGIES AND ADVERSE MEDICATION REACTIONS:

☐ NKA(s)

☐ Other (s)

HEALING AND HEALTH: (Alternative healing practices/beliefs. Apart from mental health professionals, who-- or what-- helps you deal with disability/illness and/or to address substance use problems? Describe):

NAME OF CURRENT PRIMARY CARE PHYSICIAN:

May we consult? ☐**Yes** ☐**No** **Date Last Seen:** _____ **Release of Information Form:** ☐**Yes** ☐**No**

Name Address Phone number (including area code)

CLIENT'S HOSPITAL OF CHOICE:

Name Address Phone number (including area code)

SUBSTANCE USE INFORMATION Indicate if no history of use ☐ History unknown ☐

(Describe the most recent baseline and characteristics in terms of symptoms, functioning, substance use, treatment, successful interventions, and factors (in sequence) that led to present deterioration. Identify periods of abstinence or minimal use of substances):

Type:	Date of Last Use	Amount of Last Use	Frequency and Amount of Use	Length of Time Using	Age of First Use

MENTAL STATUS EXAM:

Level of Consciousness:	☐Alert	☐Lethargic	☐Stuporous			
Orientation:	☐Person	☐Place	Time ☐Day ☐Month ☐Year		☐Current Situation	☐None
Appearance:	☐Clean	☐Well-Nourished	☐ Malodorous	☐ Disheveled	☐ Malnourished	☐ Reddened Eyes
Speech:	☐Normal	☐Slurred	☐Loud	☐Pressured	☐Slow	☐Mute
Thought Process:	☐Coherent	☐Tangential	☐Circumstantial	☐Incoherent	☐Loose Association	
Behavior:	☐Cooperative	☐Evasive	☐Uncooperative	☐Threatening	☐Agitated	☐Combative
Affect:	☐Appropriate	☐Blunted	☐Flat	☐Restricted	☐Labile	☐Other
Intellect:	☐Normal	☐Below Normal	☐Paucity of Knowledge	☐Vocabulary Poor	☐Poor Abstraction	☐ Uncooperative
Mood:	☐Euthymic	☐Elevated	☐Euphoric	☐Depressed	☐Anxious	☐Irritable
Memory:	☐ Normal	☐ Poor Recent	☐ Poor Remote	☐Inability to Concentrate	☐ Confabulation	☐Amnesia
Judgment:	☐ Normal	☐Poor	☐Unrealistic	☐Unmotivated	☐Uncertain	
Motor:	☐ Normal	☐Decreased	☐Agitated	☐Tremors	☐Tics	☐Repetitive Motions
Insight:	☐ Normal	☐Adequate	☐Marginal	☐Poor		

Note: A narrative mental status exam may be done on a progress note, in lieu of above.

Visual Hallucinations: ☐**No** ☐**Yes** Specify:_____

Auditory Hallucinations: ☐**No** ☐**Yes** Specify:_____

Delusions: ☐**No** ☐**Yes** Specify:_____

Other Information (optional):_____

POTENTIAL FOR HARM (Include risk factors, e.g. chronic illness, recent loss of job, age)

Current SI ☐ No ☐ Yes Specify plan: method, vague, passive, imminent_____

Access to means ☐ No ☐ Yes Specify_____

Previous Attempts ☐ No ☐ Yes Specify_____

Client Contract for Safety ☐ No ☐ Yes Specify in Progress Notes_____

Current HI ☐ No ☐ Yes Specify Plan: vague, intent, with/without means_____

Identified Victim ☐ No ☐ Yes Name and contact information_____

☐ No ☐ Yes Tarasoff warning _____

Client No Harm Contract ☐ No ☐ Yes Specify in Progress Notes_____

History of Violence ☐ No ☐ Yes Specify Type: past, current_____

History of Domestic Violence_____

History of Abuse ☐ No ☐ Yes Specify Type: past, current_____

Abuse Reported ☐ No ☐ Yes

Probation Officer Contact Info:

Name Address Phone (including Area Code)

CONVICTION OF FELONY AND JAIL TIME ☐ No ☐ Yes

What was the conviction for? Length of jail time?

DSM IV DIAGNOSIS: Impairment/Disability Use DSM-IV-TR Codes. Indicate (P) – Primary and (S) – Secondary	**Enter P in front of primary**	**DIAGNOSTIC CODE**
AXIS I		
AXIS I		
AXIS I		
AXIS II		
AXIS III Relevant Medical Conditions:		
AXIS IV Psychosocial and Environmental Problems:		
AXIS V Current GAF: Highest in Past Year:	**COD:** ☐**Yes** ☐**No**	

INTERPRETIVE SUMMARY: (Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client's ability and willingness to solve the clients presenting problems, addressing both mental health and substance issues from an integrated perspective).

Medical Necessity Met: ☐ Yes ☐ No NOA Issued: ☐ Yes ☐ No (Medi-Cal Clients only)

REHABILITATION/RECOVERY/RECOMMENDATIONS: (List in-house clinical services as well as names of agencies/clinicians currently being received or recommended.)

1.☐Assisted Living Services	7. ☐Employment Services	13.☐RAP Plan
2.☐Community Services	8. ☐Group Therapy	14.☐Recovery Programs/Socialization Services
3.☐ Case Management Services	9. ☐Housing Services	15.☐Substance Abuse Program (note level of care)
4.☐ Crisis Residential/Hospitalization	10.☐Individual Therapy	16.☐Support Group
5.☐Day Rehabilitation	11.☐Medical Treatment	17.☐Other
6.☐Education/Support	12.☐Medication Management	

Number and explain below:

_____ ☐Current_____
_____ ☐Proposed Referral_____
_____ ☐Current_____
_____ ☐Proposed Referral_____
_____ ☐Current_____
_____ ☐Proposed Referral_____
_____ ☐Current_____
_____ ☐Proposed Referral_____
_____ ☐Current_____
_____ ☐Proposed Referral_____

Completed by: _____ _____ _____ _____
Signature Title Date Time Spent

Co-signature: _____ _____ _____
(if required) Signature Title Date